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Umbilical cord blood hematopoietic stem cell transplantation, an alternative to bone marrow

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Umbilical cord blood hematopoietic stem cell transplantation, an alternative to bone marrow

Interactive Qualifying Project Report

submitted to the Faculty of

WORCESTER POLYTECHNIC INSTITUTE

in partial fulfillment of the requirements for the

Degree of Bachelor of Science

By

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Approved:

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Date: February 28, 2011

Abstract

Umbilical cord blood (UCB) is an alternative hematopoietic stem cell (HSC) source that can ameliorate several diseases through transplantation. The purpose of this project is to analyze clinical studies comparing HSCs from a single cord blood unit (CBU) to HSCs from bone marrow, and to explore methods of increasing limited amounts of HSCs. It was found that UCB transplantation in adults is a viable method when a matched bone marrow transplant cannot be identified. Further clinical studies using two CBUs suggest better engraftment and lower risk of relapse. However, double cord blood transplantation has been faced with the challenge of single unit dominance in most studies. *Ex vivo* expansion of UCB HSCs is another promising method to overcome limited HSC counts.

The findings of this IQP have been compiled as a journal article. The article has been submitted to the Global Journal of Health Science for publication.

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I. Introduction

Every year, thousands of patients are diagnosed with blood disorders and diseases such as leukemia, lymphoma and sickle cell anemia. Such disorders and diseases are usually cured by bone marrow transplants. The stem cells within the bone marrow are typically obtained from the family members of the patient or bone marrow registries. However, finding bone marrow stem cells that will be compatible, or genetically similar, to that of the patient is a difficult task. Such sources are also very limited. Often times, bone marrow donations from family members have a 25% chance of being compatible with the cells of the patient. A new method for curing such blood disorders and diseases has emerged as a potential alternative through the use of stem cells obtained from the umbilical cord blood.

In the 1970s, researchers considered umbilical cord blood, originally thrown away after delivery of the baby, as a potential source of stem cells. In the 1980s, researchers and doctors successfully transplanted stem cells extracted from the umbilical cord blood to cure a boy who had a genetic disease known as Fanconi Anemia, which causes bone marrow defects that result in the inability to produce blood cells. From then on, scientists have performed extensive research to explore the potential therapeutic uses of umbilical cord blood, or simply known as cord blood. To date, there are more than 70 diseases that can be potentially treated by the use of stem cells from cord blood.

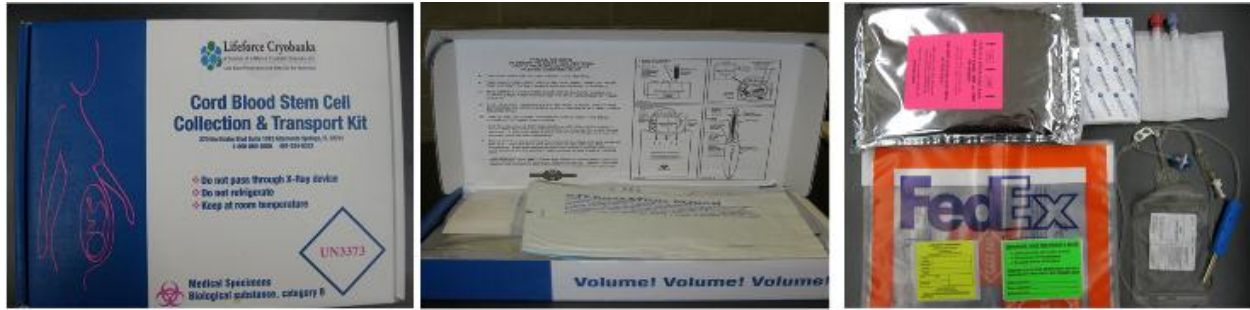
Scientists have provided evidence that the umbilical cord contains blood that is enriched with stem cells, known as hematopoietic (blood-forming) stem cells. According to Melinda Beck from the Wall Street Journal, “two tablespoons of umbilical cord blood contains about one billion stem cells”, compared to 140 billion red blood cells in two tablespoons. Although small in number compared to red blood cells, these stem cells may be used to cure genetic diseases, blood

disorders, and certain cancers. Currently, about 600,000 cord blood units are stored in cord blood banks and there have been about 20,000 (3.3%) transplants, more than any human organ transplant excluding the kidney.

Transplants performed with cord blood have various advantages over other types of transplants. Stem cells from the cord blood are more likely to be a match with a wider variety of patients as opposed to the more specific match when considering bone marrow transplants. Moreover, research has shown that the median time to find a compatible match with a cord blood is much shorter than with a bone marrow transplant. Another advantage is the noninvasive nature of the procedure. While bone marrow transplants may inflict some pain to the donor, cord blood permits easy access to stem cells with no pain to the mother or the newborn.

A disadvantage of cord blood transplants, compared to bone marrow transplants, is that the patient takes longer to recover. However, cord blood stem cells have the same healing effects as bone marrow stem cells. Another disadvantage of cord blood transplants is the reduced concentration of stem cells. Most adults will require at least 2 units of cord blood in order to experience the full healing effect.

Despite certain disadvantages, cord blood has enormous potential in medical treatment. Consequently cord blood has been collected and stored worldwide. In the United States, there are many hospitals that collect cord blood, using simple collection kits. The kits, mostly used by nurses in the facility, contain simple instructions on the collection process. Once collected, the cord blood unit is shipped to a cord blood bank.



I

II

III

Figure 1. (I) Cord blood collection kit, (II and III) Contents of the collection kit

There are two types of cord blood banks, public and private. A public bank, the more popular of the two, is the donation of stem cells of the baby to a public registry. Anyone can have access to the stem cells on a first-come first-serve basis. The donation is done with the consent of the mother and at no cost to the family. However, not all mothers meet the donation criteria. Some exclusions include mothers who have inadequate amounts of cord blood, have been through multiple gestations, have had a history of cancer, blood disease, and so on. When a patient needs a cord blood transplant, he/she will have up to a 90% chance of finding a match, a unit compatible with the cells of the patient, in a public bank. The costs of the transplant, which are generally covered by insurance, usually range from \$15,000-\$25,000. There are 38 public bank donation programs in the U.S. In Massachusetts, Brigham and Women's hospital¹ collects cord blood and is in partnership with Carolinas Cord Blood Bank, a public bank.

Private banking stores cord blood exclusively for the family of the newborn. This type of banking is typically chosen by mothers who have had a history of a particular disease in their family that may require a stem cell transplant in the future. The cord blood transplant is guaranteed to be 100% compatible with the child of the mother. However, this percentage decreases drastically to 25% compatibility with anyone else in the family. In order to bank privately, it costs about \$1500 to begin banking and \$150-\$200 annually. When a transplant is

needed, the cord blood unit is released with or without any charge depending on the bank. There are 34 private banks in the U.S. In Massachusetts, UMASS Memorial hospital² collects cord blood and is in partnership with Lifeforce Cryobanks, a public and private facility.

Cord blood banking has been prospering since it was first established in the 1990s. This alternative to bone marrow stem cells is much more available and has been effective in saving many lives. Current research is exploring better purification, collection, and storage methods of these stem cells. Financially, excluding insurance, cord blood provides a reasonable value for cord blood transplants, \$15,000-25,000, compared to \$250,000 for a bone marrow transplant which is a \$235,000 saving.

This IQP aims to provide researchers in the field of umbilical cord blood transplantation with intensive technical information. Essential constituents of the cord blood and their roles in clinical uses were first investigated. Hematopoietic stem cell transplantation, different conditioning regimens used to treat the patients and clinical results of studies performed on bone marrow transplants and umbilical cord blood transplants were further elucidated. Moreover, two methods to enhance the treating potentials of umbilical cord blood were examined, namely double cord blood transplantation and *ex vivo* expansion of cord blood. Additionally this study explained the processing and handling of umbilical cord blood, including cord blood extraction, cryopreservation, banking and retrieval. Lastly public awareness of umbilical cord blood banking was tested on faculty and students at Worcester Polytechnic Institute (**Appendix 1**).

¹<http://www.brighamandwomens.org/womenshealth/corddonor/>

²<http://www.umassmemorial.org/MedicalCenterIP.cfm?id=4323>

II. Objectives

The major objectives of this review are:

1. To understand the basic physiology of umbilical cord and essential constituents of cord blood and their roles in umbilical cord blood transplantation
2. To understand hematopoietic stem cell transplantation and conditioning regimens, namely myeloablative, non-myeloablative and reduced intensity conditionings, treated to patients undergoing stem cell transplants
3. To review and analyze results of clinical studies performed on patients with different malignancies using umbilical cord blood transplantation and bone marrow transplantation
4. To elucidate the advantages and disadvantages between umbilical cord blood transplantation and bone marrow transplantation
5. To investigate methods to further enhance therapeutic potentials of umbilical cord blood transplantations
 - a. To examine double cord blood transplantation and to review and analyze results of clinical studies performed on patients with different malignancies using double cord blood transplantation
 - b. To investigate different techniques used to expand umbilical cord blood *ex vivo*
6. To understand umbilical cord blood processing and handling for therapeutic uses
 - a. To examine umbilical cord blood extraction and cryopreservation
 - b. To investigate the differences between private and public cord blood banking

7. To investigate public awareness of umbilical cord blood banking

III. Methodology

The purpose of this study is to investigate the therapeutic potentials and effectiveness of the umbilical cord blood. In order to accomplish this goal, numerous clinical research articles relating to the clinical studies performed using umbilical cord blood were intensively reviewed. Moreover, two informal interviews were conducted at UMASS Medical Center and Auxocell Laboratories to obtain further information.

The history of umbilical cord blood as a therapeutic tool was investigated and important achievements resulted from umbilical cord blood transplantations were described. Essential constituents of the umbilical cord blood which contribute to medical applications were examined. Furthermore, clinical studies that have been performed recently were investigated and results were interpreted and compared. Further research was performed to describe the handling and processing of the umbilical cord blood to be used in clinical research.

Furthermore, two personal interviews with technical experts in the field were conducted. One interview was performed at the UMASS Medical Center with Dr. Mary Herlihy who kindly explained blood extraction, collection, banking processes and so on (An audio file recorded during the interview is attached) (**Appendix II**). A second interview was conducted at Auxocell Laboratories with Dr. Rouzbeh Taghizadeh, who provided important technical information concerning umbilical cord blood (**Appendix II**).

In order to disseminate the information to the specific audience of clinical researchers, the findings were compiled together as a manuscript for publication at the Global Journal of Health Science. Dr Guisheng Song, one of the editorial board members, was contacted regarding the publication of the manuscripts. Currently, the manuscript is under reviewing process for publication. Email correspondence with Dr. Guisheng Song is included in **Appendix II**.

**The following article has been submitted to the Global
Journal of Health Science.**

Umbilical cord blood hematopoietic stem cell transplantation, an alternative to bone marrow

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Abstract

Umbilical cord blood (UCB) is an alternative hematopoietic stem cell (HSC) source. It is widely applicable for ameliorating several diseases through HSC transplants. One of the few disadvantages of this source of stem cells is the limited amount of HSCs that can be extracted from each cord blood unit (CBU). Single CBU transplantation seems to be more ideal in lower weight, younger patients. Adult clinical studies comparing HSCs from a single CBU and HSCs from bone marrow indicate that umbilical cord blood transplantation is a viable method when a matched bone marrow transplant cannot be identified. Further clinical studies using two CBUs suggest better engraftment and lower risk of relapse. However, double cord blood transplantation has been faced with the challenge of single unit dominance in most studies. *Ex vivo* expansion of UCB HSC is another promising method to overcome limited HSC counts.

Keywords: umbilical cord blood, hematopoietic stem cells, umbilical cord blood transplantation, double cord blood transplantation, *ex vivo* expansion

1. Introduction

Originally thrown away after the delivery of the baby, umbilical cord blood (UCB) was first considered as a source of stem cells in the 1970s (Mayani, Alvarado-Moreno, & Flores-Guzmán, 2003). Recent advances in the potential of UCB have revealed therapeutic uses of HSCs (Eapen *et al.*, 2007; Gluckman *et al.*, 1989; Rocha *et al.*, 2001). The presence of hematopoietic progenitor cells in human UCB was first evidenced by Knudtzon in 1974 (Knudtzon, 1974). Approximately 10 years later, the presence of more primitive hematopoietic progenitor cells was observed by Leary and Ogawa (Leary & Ogawa, 1987). UCB has the potential to be used as a therapeutic tool due to its abilities to engraft (Broxmeyer *et al.*, 1989). In comparison to bone marrow (BM) hematopoietic stem cells (HSCs), UCB is easier to attain, more available, and requires less compatibility with the patient.

UCB has been a successful alternative to BM as a source of HSCs for treating a variety of hematologic disorders and malignant/non-malignant diseases such as leukemia, lymphoma, and sickle cell anemia (Broxmeyer, 2010; Higuchi *et al.*, 2010). UCB was first tested on a young boy who had Fanconi Anemia, an autosomal recessive disorder. Fanconi Anemia is characterized by hematological abnormalities and BM failure. The transplant of UCB from a female HLA-identical sibling allowed the boy to regenerate all hematopoietic efficacies that were limited by the disease (Gluckman *et al.*, 1989). This success has been a vital motivation to all subsequent research on UCB. The first unrelated umbilical cord blood transplant (UCBT) was performed in 1993 on patients with malignant and non-malignant diseases (Kurtzberg *et al.*, 1996). In 1996, Laporte *et al* reported successful UCBT in an adult with chronic myelogenous leukemia from an unrelated donor (Laporte *et al.*, 1996). This innovative use of stem cells has led to a wide increase of UCB banking. As a result, expecting mothers are now more likely to bank their newborn's UCB in cord blood banks (CIBMTR) (Pasquini & Wang, 2010).

Here, we provide a review of the most recent research performed on UCBTs. We first examine the essential constituents of UCB including HSCs and mesenchymal stem cells (MSCs). We further review the advantages and disadvantages of UCBT HSCs as opposed to bone marrow transplant (BMT) HSCs by examining clinical trials. Since there are less HSCs in UCB than in BM, we discuss methods that overcome the limitation of HSCs from a single cord through double cord blood transplantation (DCBT) and *ex-vivo* expansion. Additionally, we analyze clinical studies performed on DCBT which use various types of conditioning regimens including reduced intensity conditioning (RIC), myeloablative conditioning (MAC), and non-myeloablative conditioning (NMAC). Lastly, we discuss the processes of UCB extraction, cryopreservation and banking.

2. Essential Constituents of Umbilical Cord Blood

The umbilical cord (UC) is the basic life-line support for all newborns. It is the essential tube in which all nutrients and nourishments are transported from the mother to the embryo. Following delivery, the umbilical cord is usually clamped and discarded. The human umbilical cord begins to form in the first 5 weeks of pregnancy. The allantois, a membrane formed out of the gut, contains umbilical vessels that attach the fetus to the developing placenta. Blood vessels typically develop from the yolk sac, which will then combine with the umbilical vessels. The amnion or the membrane surrounding the amniotic fluid envelops the allantois and the yolk sac, forming the developing umbilical cord. In the following months leading up to birth, the umbilical cord begins to insert deeper into the abdomen of the fetus (Kurt Benirschke & Peter Kaufmann, 2000). The umbilical cord consists of two arteries and one vein arranged in a helical structure (**Figure 1**). The two arteries of the umbilical cord spiral around the umbilical vein, making them stiffer and more difficult to rupture. Opposite to the arteries and veins of the human heart (except for the pulmonary arteries), umbilical cord arteries and veins carry deoxygenated blood to the placenta and oxygenated blood from the placenta to the developing fetus, respectively. The three vessels of the umbilical cord

are embedded in a connective tissue gelatinous base known as the Wharton's Jelly which insulates the umbilical cord.

A striking difference between the umbilical arteries and vein is observed in the endothelial cells at 10 weeks gestation. The endothelial cells of the arteries become richer in glycogen. At 15 weeks gestation, venous endothelium contains the most amount of rough endoplasmic reticulum and thereafter decreases until almost none is seen by mid-pregnancy. Arterial endothelium contained rough endoplasmic reticulum that progressively increased over the course of the pregnancy.

2.1 Hematopoietic Stem Cells

HSCs are multipotent and have the capability to self-renew and differentiate into all mature blood cells including myeloids such as granulocytes, monocytes, leukocytes, erythrocytes, and megakaryocytes, and lymphoids such as T-lymphocytes and B-lymphocytes (**Figure 2**) (Gunsilius, Gastl, & Petzer, 2001; Higuchi *et al.*, 2010). HSCs in UCB are similar to those in BM and peripheral blood in their capacity for differentiation. They can self-renew and they contain erythroid and granulocyte-macrophage progenitor cells when examined in an *in vitro* colony assay (Broxmeyer *et al.*, 1989).

Current scientific investigation is attempting to determine the best marker for HSCs. The most recent significant constituents of UCB are erythrocytes, endothelial cells, MSCs, HSCs, and Tregs. Many other mononuclear cells are found in UCB, making it difficult to identify HSCs. A common marker used is cell determinant-34 (CD34), a glycoprotein found on the surface of the HSCs and progenitor cells that is important for adhesion with neighboring cells (Soiffer, 2008). Simple combinations of markers that efficiently select for HSCs have not yet been determined. Protocols experimenting with complex combinations of markers have provided a more efficient method of detecting these stem cells. One such protocol begins by reducing the amounts of cells that portray any lineage-specific markers and then using the remaining cells to positively select for Sca-1⁺ Lineage-c-kit⁺ cells (Osawa, Hanada, Hamada, & Nakauchi, 1996). However, this protocol only gives 20% multilineage reconstitution (Morrison, Hemmati, Wandycz, & Weissman, 1995; Osawa *et al.*, 1996; Spangrude, Brooks, & Tumas, 1995; Wagers, Sherwood, Christensen, & Weissman, 2002). More recently, a protocol using the signaling lymphocyte activation molecule (SLAM) family of markers were recognized to distinguish between 'true' HSCs and primitive progenitor cells. Microarray analysis was performed on three markers from the SLAM family, and the most purified HSCs pertained to CD150⁺CD244⁻CD48⁻ cells (Kiel *et al.*, 2005).

2.2 Mesenchymal Stem Cells

MSCs have multipotential capabilities to self-renew and differentiate into various cellular lineages including adipocytes, osteocytes, chondrocytes, cardiomyocytes, hepatocytes, and nerve cells (Chen, Shao, Xiang, Dong, & Zhang, 2008; Kang *et al.*, 2006; Kestendjieva *et al.*, 2008; Romanov, Svintsitskaya, & Smirnov, 2003). Their proliferative properties and their ability to migrate to sites of inflammation make MSCs highly desirable for tissue engineering and cell-based therapy (Chen *et al.*, 2008; Romanov *et al.*, 2003).

To date, BM is the most common source of MSCs (Kestendjieva *et al.*, 2008). BM MSCs have certain disadvantages such as the invasive nature of aspirating BM, the drop in cell number (1 MSC in 10⁴ nucleated BM cells at birth to 1 in 2x10⁶ at the age of 80) and reduction of proliferative potentials with donor's age (Kestendjieva *et al.*, 2008). UCB provides an alternative source of MSCs that possess better proliferative capabilities than BM MSCs (Rodeck & Whittle, 2009; Wang *et al.*, 2004).

Previous research by Panepucci *et al.* (Panepucci *et al.*, 2004) and Jeong *et al.* (Jeong *et al.*, 2005) showed that MSCs from UCB have similar differentiative properties to MSCs from BM. Similarities include abilities to differentiate into adipose tissue, neuronal tissue, bone forming capacity, hepatocyte-like cells, neuroglial-like cells, bone and cartilage (Rodeck & Whittle, 2009). Moreover, MSCs from UCB show similar cell morphology and immune phenotype to MSCs from BM (Kern, Eichler, Stoeve, Kluter, & Bieback, 2006; Romanov *et al.*, 2003). However, previous attempts to isolate MSCs from UCB have been unsuccessful or have resulted in low yields (compared to yield rates of 100% from BM) (Bieback, Kern, Kluter, & Eichler, 2004; Kern *et al.*, 2006). Recent research has shown that UCB MSCs may be expanded due to their higher proliferation rate and long culture period (Kern *et al.*, 2006).

Similar to HSCs, surface markers used to identify MSCs are not specific to MSCs but also to other cellular lineages (Bieback & Kluter, 2009; Li, Gollapudi, Patterson, Huang, & Tuan, 2010; Westwood & Clements, 2007). Therefore, a combination of expressed and non-expressed markers are used to identify MSCs. Positive MSC markers include CD29, CD44, CD73 (SH-3, SH-4), CD90 (Thy-1), CD105 (SH-2, Endoglin), and CD166 whereas

negative markers include CD11, CD14, CD19, CD31, CD34, CD45, and CD79 (Bieback & Kluter, 2009; Li *et al.*, 2010; Westwood & Clements, 2007).

2.2.1. MSCs as Immunoregulators

MSCs are considered to assist in lowering graft-versus-host-disease (GVHD) in UCBT (Ringdén *et al.*, 2006). This may be attributed to the ability of MSCs in reducing T-cell proliferation and cytokine production (Aggarwal & Pittenger, 2005; Glennie, Soeiro, Dyson, Lam, & Dazzi, 2005; Maitra *et al.*, 2004). Exact mechanisms of how MSCs perform their immunosuppression remain unknown. It has been suggested that factors such as transforming growth factor- β (TGF- β), nitric oxide, and interleukin-10 (IL-10) co-function with MSCs to cause immunosuppression (Batten *et al.*, 2006; Groh, Maitra, Szekely, & Koç, 2005; Sato *et al.*, 2007). Further research is required to determine the feasibility of using MSCs along with UCB HSCs to lower GVHD and improve engraftment rates.

2.3 Regulatory-T Cells as Immunoregulators

T-regulatory cells (Tregs) are immune suppressor cells that restrain allogeneic immune responses. Their ability to respond to foreign or self-antigens allows them to maintain the immune system at a homeostasis (Sakaguchi, Yamaguchi, Nomura, & Ono, 2008). Tregs are typically characterized as CD4⁺CD25^{hi} T cells that express the fork head box transcription factor (FOXP3) (Fontenot *et al.*, 2005). FOXP3 is crucial for T cell activation and in regulating a variety of immune reactions. It is also the most reliable marker for Tregs.

Tregs in UCB may play a crucial role in hematopoietic stem cell transplants (HSCT). Studies on mice administered with allogeneic HSCs have determined that the depletion of Tregs triggers an increased T cell response to tumors, self-antigens, and pathogens, resulting in increased GVHD in recipients (Anderson *et al.*, 2004; Chen *et al.*, 2007; Cohen, Trenado, Vasey, Klatzmann, & Salomon, 2002; Taylor, Lees, & Blazar, 2002). Conversely, the presence of Tregs resulted in fewer cases of GVHD (Taylor *et al.*, 2004; Trenado *et al.*, 2003). Patients who receive BM transplants are at a higher risk of developing GVHD as compared to patients who receive UCBT (Kim & Broxmeyer). Reasons for such results remain unknown but it is speculated that the lower percentages of GVHD in UCBT recipients may be due to the Tregs present in UCB (Kim & Broxmeyer). The lack of human clinical trials, mainly due to the complexity of isolating human Treg populations, makes it difficult to validate such a speculation.

3. Hematopoietic Stem Cell Transplantation

Once a HSC unit has been identified for a patient, he/she must first be administered on a conditioning regimen 5-10 days before the HSC transplant (Carrier & Ledingham, 2004). Conditioning regimens are chemotherapy only or chemotherapy combined with total body irradiation (TBI) treated to patients undergoing allogeneic HSCTs (Vriesendorp, 2003). The conditioning regimen destroys diseased cells in the patient's body, opens up space in the bone marrow for new cells, and reduces the risk of rejection by suppressing the immune system (Bacigalupo *et al.*, 2009; Casper *et al.*, 2004). The intensity of the conditioning regimens given to patients is crucial and may vary according to age or comorbidities (Nakamae *et al.*, 2009). One of the most common conditioning regimens for patients with acute leukemia or high-risk lymphoma is cyclophosphamide combined with total body irradiation (Cy/TBI). TBI is radiation performed to the entire body as opposed to the specific infected area. This therapy aids in suppressing the patient's immune system to allow for reduced rejection of the transplant. Another common type of conditioning regimen includes busulfan and cyclophosphamide (Bu/Cy) for patients with chronic myelogenous leukemia (CML). Along with the conditioning regimen, the patient receives chemotherapy treatments. Many of these preparatory therapies for transplant are associated with side effects and risk factors that patients must be informed of beforehand.

3.1 Conditioning regimens

There are three common categories of conditioning regimens: (1) myeloablative conditioning (MAC), (2) non-myeloablative conditioning (NMAC) and (3) reduce intensity conditioning (RIC).

MAC regimens are associated with irreversible pancytopenia and myeloablation. Such conditioning requires stem cell support (Bacigalupo *et al.*, 2009). MAC is administered to young patients (<50 years of age) without comorbidities due to its high toxicity (Mielcarek & Storb, 2003). Even in young patients, MAC is associated with high treatment related mortality rates (Kanda *et al.*; Vriesendorp, 2003). Common MAC regimens include either cyclophosphamide 120 mg/kg and TBI (12 to 14.4 Gy) or 16 mg/kg busulfan (Mielcarek & Storb, 2003). Such combination of high doses of TBI and/or alkylating agents is so intense that autologous hematologic recovery is disabled and thus hematopoiesis in patients can only be restored by transplanted HSCs (Bacigalupo *et al.*, 2009).

Bacigalupo *et al.* defined NMAC regimens as those that cause minimal cytopenia and do not require stem cell support (Bacigalupo *et al.*, 2009). NMAC regimens are developed to reduce toxicity in HSCTs. Such reduction in cytotoxicity provides better results in HSCTs with older or medically weak patients (Mielcarek & Storb, 2003). NMAC is associated with minimally myelosuppressive regimens combined with intensive immunosuppression post-transplant to ensure engraftment (Nakamae *et al.*, 2009). NMAC regimens include the use of fludarabine and/or reduced chemotherapy and radiation (Bacigalupo *et al.*, 2009). Fludarabine is important in NMAC due to its ability to reduce high rate of graft rejection (Horwitz & Chao, 2010). Common NMAC regimens include combinations of busulfan/fludarabine or TBI 200 cGy/fludarabine (Horwitz & Chao, 2010). In addition, patients are treated with cyclosporine and mycophenolate mofetil as post-graft immunosuppression (Horwitz & Chao, 2010; Nakamae *et al.*, 2009).

RIC regimens can neither be defined as MAC or NMAC. Compared to MAC, RIC has a minimum TBI or alkylating agent dosage reduction of 30% (Bacigalupo *et al.*, 2009). It differs from NMAC in that RIC causes prolonged cytopenia and requires stem cell support (Bacigalupo *et al.*, 2009). According to the Center for International Blood and Marrow Transplant Research (CIBMTR) and National Marrow Donor Program, RIC regimens have to meet one or more of the following criteria (Giralt, 2005):

1. ≤ 500 cGy total-body irradiation,
2. ≤ 9 mg/kg total busulfan dose,
3. ≤ 140 mg/m² total melphalan dose,
4. ≤ 10 mg/kg total thiotepa dose and
5. Includes a purine analog—fludarabine, cladribine, or pentostatin.

The aim of RIC regimes is to prevent graft rejection and to establish stable donor-derived hematopoiesis while maintaining low rates of non-hematologic toxicity (Giralt, 2005; Satwani, Cooper, Rao, Veys, & Amrolia, 2008).

The donor HSCs are transplanted after a patient has been placed on a conditioning regimen. The donor HSCs are infused into the patient's bloodstream through a typical central line. The HSCs will travel along the bloodstream throughout the body for several days, after which they begin to dwell into the spaces of the patient's bone marrow. At this point, the HSCs will grow and will begin producing new blood cells after 1-2 weeks. White blood cells will be formed first, then red blood cells, and lastly platelets. The engraftment, or the process by which the patient's body accepts the new HSCs, will follow 1-3 weeks after transplantation.

3.2 BM vs. UCB

UCBTs are currently one of the most common types of transplants in the United States, as evidenced by the increasing number of transplantation centers (**Figure 3**) (National Marrow Donor Program, 2010b). The outcomes of transplants from 6/6 matched BM vs. unrelated UCB have been compared in various studies (**Table 1**) (Laughlin *et al.*, 2004; Rocha *et al.*, 2004; Takahashi *et al.*, 2004).

A study performed by Laughlin *et al.* included 150 patients with 1 or 2 HLA mismatched CUBs (Laughlin *et al.*, 2004). The study also included 367 patients receiving 6/6 HLA matched bone marrow units and 83 patients receiving 5/6 HLA matched BM units. UCBT patients had a median body weight less than BMT patients (68kg vs. 76kg). UCB patients received ten-fold less total nucleated cells (TNCs) compared to BMT patients (0.22×10^8 vs. 2.4×10^8 per kg of body weight). The recovery times for neutrophils (>500 cells/mm³) and platelets (20 000 cells/mm³) were both delayed for UCBT recipients compared to BMT recipients (27 days vs. 18 days, 95% CI and 60 days vs. 29 days, 95% CI). Similarly cumulative incidences for neutrophil recovery at 100 days and platelet recovery at one year after matched BM transplants were significantly higher than in UCBT. However, compared to 1-HLA mismatch BMTs, UCBTs resulted in similar cumulative incidences of neutrophil recovery at 100 days ($p=0.29$) and platelet recovery at one year ($p=0.16$). The rate of acute II-IV GVHD was similar between matched BMT and UCBT (48% vs. 41%, 95% CI). Patients who survived after 90 days were assessed for chronic GVHD which was higher in UCBT patients than in matched BMT patients (35% vs. 51%). However, UCBT patients developed less acute II-IV GVHD occurrences than mismatched BMT patients (95% CI) while chronic GVHD rates were similar. TRM was significantly higher in UCBT patients than in matched BMT patients (63% vs. 46%). Treatment failures developed in 69% of matched BMTs and 81% of UCBTs. Leukemia relapse was observed in 26 out of 150 UCBT patients and 83 out of 367 BMT patients. The DFS rate after 3 years was 23% and 33% for UCBT and BMT patients, respectively. After 100 days, the rates of death in UCBT patients were significantly higher than in matched BMT patients (70% vs. 50%, $p<0.001$). The proportion of deaths due to infection was higher in UCBT patients than in both matched and mismatched BMT patients. Although TRM, rate of treatment failure, and overall

mortality were significantly higher in UCBT patients than in matched BMT patients, the rates were similar with BMTs that have 1 HLA mismatch.

A four-year retrospective study by Rocha *et al.* compared 98 UCBTs and 584 BMTs in patients diagnosed with acute leukemia (Rocha *et al.*, 2004). UCBT patients were diagnosed with more advanced leukemia at the time of transplantation ($p < 0.001$). The median age and body weight of UCBT patients were both less than BMT patients (24.5 years and 58kg vs. 32 years and 68kg). All BMTs were 6/6 HLA matched while 90% of UCBTs were 1-2 HLA mismatched. Similar to the study by Laughlin *et al.* (2004), UCBT recipients received ten-fold less TNCs compared to BMT recipients (0.23×10^8 vs. 2.9×10^8 per kg of body weight). ANC (>500 cells/mm³) engraftment was significantly delayed in UCBT (26 days vs. 19 days). Primary graft failure occurred in 43 BMT patients and 20 UCBT patients while secondary graft failure occurred in four BMT patients and one UCBT patient. UCBT patients were significantly less likely to experience acute II-IV GVHD when compared to BMT patients (26% vs. 39%, $p = 0.008$) while there was no significant difference in chronic GVHD between the two groups (30% vs. 46%, $p = 0.07$). A two-year follow-up demonstrated that TRM and DFS were insignificant between the two groups (44% vs. 38%, $p = 0.13$, and 33% vs. 38%, $p = 0.06$).

A single center study was performed in Japan by Takahashi *et al.* in 2004 comparing 68 UCBTs and 45 BMTs (Takahashi *et al.*, 2004). Median age of UCBT patients was higher than BMT patients while median weight was higher in BMT patients (36 years and 55.1kg vs. 26 years and 59.6kg). Out of 68 UCBT patients, 75% received 4-5/6 matched CBUs. Most of BMT patients received matched BMTs while only six patients received 5/6 HLA matched BMTs. The patients underwent MAC regimens consisting of cyclophosphamide and TBI. UCB grafts contained more than 2.0×10^7 cells per kg and a median of 0.9×10^5 CD34⁺ progenitor cells per kg. Within 28 days after transplantation, 4% of UCBT patients died while 8% experienced primary graft failure. UCBT recipients had a delayed ANC (>500 cells/mm³) engraftment than BMT recipients (22 days vs. 18 days). Platelet ($>20,000$ cells/mm³) recovery was observed after 40 and 25 days for UCBTs and BMTs, respectively. The overall myeloid engraftment rates on day 42 were 92% for UCBT and 100% for BMT. Despite higher HLA mismatches in UCBTs, acute II-IV and III-IV GVHD incidences were lower than BMTs. Among the patients surviving 100 days after transplantation, 78% of patients receiving UCBTs and 74% of those receiving BMTs were affected by chronic GVHD. The hazard ratio for one-year TRM incidence was lower in UCBT patients compared to BMT patients (0.32 vs. 1.0, 95% CI). However, although there is no apparent risk of relapse in the two groups ($p = 0.73$), relapse was slightly lower in UCBT recipients (hazard ratio of 0.76 vs. 1.0, 95% CI). DFS was significantly better among patients receiving UCBTs than BMT patients (74% vs. 44%). Deaths of BMT patients were more likely due to GVHD while no correlation between death and GVHD was observed in UCBT patients. TRM and DFS rates were surprisingly better in UCBT patients than in BMT patients compared to other studies (Laughlin *et al.*, 2004; Rocha *et al.*, 2004). A possible explanation for the improved TRM and DFS rates in this study is that it evaluated patients only from a single center. Lower incidences of acute II-IV GVHD may be explained due to lower degree of diversity for HLA and minor histocompatibility antigens among more homogenous population in Japan. Moreover, it has been shown that the Japanese population expresses a higher frequency of the gene that induces interleukin-10 production which may also contribute to lower acute II-IV GVHD incidences (Lin *et al.*, 2003).

3.2.1 Advantages vs. Disadvantages

Based on the UCBT and BMT studies performed one can determine the advantages and disadvantages of both transplant types. Compared to HSCs from BM, HSCs from UCB are able to engraft not only with reduced GVHD, but also with less severe cases of GVHD (Rocha *et al.*, 2004). A possible reason may be due to immunoregulators such as Tregs or MSCs, as described earlier, that are mixed in with UCB. In addition, UCB allow for more diverse transplants due to its ability to engraft despite a higher degree of HLA mismatch. BMTs require at least a 5/6 HLA match while UCBTs require at least a 4/6 HLA match (although a 3/6 match has also proved to be functional) (J. N. Barker *et al.*, 2002). This allows for a much higher probability for finding a patient-donor match. A statistical analysis has shown that patients seeking a CBU will be able to find a 4/6 HLA match 99% of the time (Beatty, Boucher, Mori, & Milford, 2000; Stevens, Scaradavou, Carrier, Carpenter, & Rubinstein, 2005). The probability of finding a 5/6 CBU with a sufficient cell dose ($>2 \times 10^7$ TNC/kg) is 80% given that at least 170,000 CBUs are available. Moreover, if a patient is identified for an HSC transplant, the process of finding a CBU match is quicker (days-weeks) than identifying a match for a BMT (weeks-months). The average time for identifying a donor of a CBU is 13.5 days while it is 45 days to identify a BM donor (Barker *et al.*, 2002). It is faster to identify a matching CBU because it will be available for transplant as soon as the unit is identified. It takes longer to acquire a BMT because first, a donor must be identified (average of 19 days), and second, a 30-day period necessary to clear the donor (J. N. Barker *et al.*, 2002). Extraction of HSCs from UCB is noninvasive compared to extraction of HSCs

from BM. While BMTs require the use of pervasive extraction procedures (aspiration) which will exert some pain to the donor, cord blood permits easy access to stem cells with no pain to the mother or the newborn. Furthermore, extracting HSCs from BM can lead to donor infection.

A disadvantage of UCB is that the patient has both a longer time-to-neutrophil recovery and time-to platelet recovery. Clinical trials have shown that UCB displayed a time-to-neutrophil recovery (neutrophils > 500 cells/mm³) ranging from 22-27 days as opposed to an average of 18 days for unrelated BMTs (Taghizadeh & Sherley,). Moreover, UCB presented a time-to-platelet (platelets $> 20\,000$ cells/mm³) recovery of 60 days compared to 29 days for BM transplants (Laughlin *et al.*, 2004). Similarly, another clinical trial exhibited a time-to-neutrophil recovery (neutrophils > 500 cells/mm³) average of 27 days for HLA mismatched UCB and 19 days for HLA matched BM recipients (Rocha *et al.*, 2004).

The TNC dose transplanted per kg of body weight is directly correlated with the outcomes of the transplantation (Lim *et al.*, 1999; Tung, Parmar, Robinson, De Lima, & Shpall, 2010). TNC dose is critical in neutrophil recovery and higher CD34⁺ cell counts, which is associated with higher engraftment rate, TRM, and improved survival (Barker *et al.*, 2005; Tung *et al.*, 2010). Patients receiving UCBTs of cell doses less than 1.8×10^7 TNCs and 1.7×10^5 CD34⁺ cells per kilogram of the recipient body weight had inferior engraftment and survival rates (J. E. Wagner *et al.*, 2002). On average, TNCs in UCB are approximately 10 fold lower than BM. These low amounts of CD34⁺ cells may provide an explanation for the delayed engraftment of UCBTs (Eapen *et al.*, 2007; Laughlin *et al.*, 2004; Rocha *et al.*, 2004; Takahashi *et al.*, 2007). Laboratory techniques as well as purification procedures are currently being explored to determine the most efficient methods of collecting or culturing CD34⁺ cells.

4. Double Cord Blood Transplantation

Due to the limited cell dose available from one CBU, UCBTs are more ideal for younger, lower weight, patients. Even in UCBTs with small children, delays in engraftment and immune reconstitution are observed compared to other stem cell sources (Tung *et al.*, 2010). Additionally, patients with a total body weight of more than 45 kg who receive only one CBU are associated with decreased neutrophil and platelet recovery and higher rates of engraftment failure (Tung *et al.*, 2010). In order to overcome low cell dose in UCB HSCs, two methods are often employed, DCBT and *ex vivo* expansion.

In DCBT, two CBUs, each of which has no more than 2/6 HLA mismatches (low resolution typing of HLA-A and -B or high resolution typing of HLA-DRB1), are infused together to transplant into adults and large children (Barker *et al.*, 2005; Brunstein *et al.*, 2007; Rocha *et al.*, 2010; Wagner, 2009). The two CBUs chosen for transplantation must have at least a 4/6 HLA match between the units themselves and with the patient.

When a CBU is selected for transplantation, the TNC dose is used to determine if a single unit is sufficient for treatment (**Figure 4**) (Barker *et al.*, 2005; Brunstein *et al.*, 2007; Wagner, 2009). A minimum TNC dose of $2.5\text{--}3 \times 10^7$ per kg of body weight is recommended for each of the two closely matched (5/6 or 6/6 matches) UCB units (Tung *et al.*, 2010). A greater mismatch between the two CBUs requires a higher TNC count (Tung *et al.*, 2010). Research suggests use of two CBUs if a single HLA-matched unit has TNC dose of $< 3.0 \times 10^7$ per kg (Brunstein *et al.*, 2007; Wagner, 2009). However, Barker *et al.* (Barker *et al.*, 2005) performed DCBTs on patients when the TNC dose of a single unit was less than 3.5×10^7 per kg in order to increase graft cell dose for patients. Barker *et al.* (Barker, Scaradavou, & Stevens, 2010) further suggested that if the CBU is only 4/6 HLA matched, then the cell dose should be as high as 5.0×10^7 per kg.

4.1 DCBTs using different conditioning regimens

Various DCBT studies have been performed separately on MAC, NMAC, and RIC (**Table 2**) (Ballen *et al.*, 2007; Barker *et al.*, 2005; Barker *et al.*, 2009; Brunstein *et al.*, 2007; Cutler *et al.*, 2010; Kanda *et al.*, ; Majhail, Brunstein, & Wagner, 2006; Rodrigues *et al.*, 2009; Verneris *et al.*, 2009; Yoo *et al.*, 2011). The largest MA study performed by Verneris *et al.* included 93 DCBT patients and 84 single UCBT patients all diagnosed with acute leukemia or transplantation in first or second complete remission (CR1-2) (Verneris *et al.*, 2009). Median age and weight of DCBT patients were 24 years (range 9-57 years) and 69kg, respectively. At least 90% of DCBT and single cord recipients received two 4-5/6 HLA matched units. The majority of AML and ALL patients were in CR1 or CR2, and a sub-majority who underwent transplantation in CR1 had high risk clinical features. DCBT recipients received a median infused TNC dose of 3.6×10^7 per kg of body weight while single cord recipients received a median dose of 3.3×10^7 per kg of body weight. ANC engraftment recovery was similar between the two groups. Grade II-IV acute GVHD occurred more frequently in DCBT patients than single cord patients (48% vs. 29%, $p < 0.01$). A similar trend is observed with chronic GVHD (18% vs. 10%, $p = 0.06$). Relapse was significantly lower

in CR1-2 DCBT patients than single cord blood transplant patients (16% vs. 31% $p < 0.03$). Verneris *et al* have determined that two risk factors were associated with relapse, 1) disease state 2) use of two partially matched CBUs. DFS was similar among the two groups after 5 years (51% vs. 40%, $p=0.35$). A DCBT study by Barker *et al*. included recipients of a similar age group. They received similar amounts of TNCs, which resulted in analogous ANC engraftment (Barker *et al.*, 2005). Correspondingly, more patients were likely to have acute II-IV GVHD than chronic GVHD (65% and 23%). DFS after 10 months was achieved in 57% of patients. Similar occurrences were observed in other clinical studies (Barker *et al.*, 2009; Kanda *et al.*).

The largest NMA study using two units of UCB was performed by Brunstein *et al.* and included 93 patients diagnosed with high risk hematologic diseases (Brunstein *et al.*, 2007). Median age and weight of patients were 51 years and 76 kg, respectively. The majority of recipients received two 4-5/6 matched units. Patients received combined median TNC dose of 3.7×10^7 and median CD34+ dose of 1.2×10^7 per kg of body weight. ANC engraftment recovery was achieved after 12 days. There were fewer cases of chronic (23%) than acute II-IV GVHD (59%). Acute GVHD did not associate with HLA matching. A three-year follow up assessed a 38% DFS and TRM of 26%. Preexisting high-risk clinical features seemed to be the primary predictors of increased TRM as patients lacking these features showed low TRM. Overall survival was not influenced by age but was rather attributable to severe GVHD and preexisting high-risk clinical features. Chimerism of the two UCB units was observed in 81 patients. Chimerism from each CBU decreased over time (43% at day 21, 9% at day 100, and 0% at one year) until one unit predominated. The contribution of donor-derived cells to the predominant unit was 7% at day 21 and 0% at day 100. Factors including cell doses and HLA matching were not predictive of the dominating unit. A possible reason that a relationship was not observed might be attributable to the sequential (~1 hour) infusion of the two units. Ballen *et al* allowed 3.5-4.5 hours between the infusion of the first and second unit, and observed that the first unit infused predominated 76% of the time (Ballen *et al.*, 2007).

In a previous study performed by Ballen *et al.*, 21 patients were treated by same RIC with fludarabine/melphalan/rabbit antithymocyte globulin but different GVHD prophylaxis consisted of cyclosporine and mycophenolate mofetil. The median age and weight were 49 years and 78 kg respectively. The median infused TNC dose was 4.0×10^7 and that of CD34+ was 1.9×10^5 per kg. After transplantation, two patients experienced primary graft failure. Among the remaining patients, the median time to ANC (>500 cells/mm³) and platelet count ($>20,000$ cells/mm³) were 20 days and 41 days respectively. Grade II-IV acute GVHD developed in 40% of the patients. Among 16 patients evaluable, 31% suffered chronic GVHD. TRM was 14% at day 100 and 19% at 6 months. The two year follow up for OS and DFS were 71% and 55%. Chimerism was evaluated among 17 patients. Both donor units were initially identified in 6 patients. However, after 12 weeks post-transplantation, single unit predominance was observed in 13 patients, double cord chimerism was observed in 1 patient, and host hematopoiesis along with single cord blood was observed in 3 patients. Of all the patients with single unit predominance, the predominant unit infused first ($p=.049$) and generally had higher TNC ($p=.071$) and CD34+ ($p=.120$) counts.

Cutler *et al.* recently performed a study describing their experiences with 32 patients who underwent DCBT. All patients received RIC of fludarabine (180mg/m^2), melphalan (100mg/m^2) and rabbit antithymocyte globulin (6.0mg/kg) and received sirolimus, which is a potent immunosuppressant that prevents T-cell mediated alloimmunity, and tacrolimus to prevent acute GVHD. The median age and weight of the patients were 53 years and 75.9 kg respectively. Majority of patients (91%) received two 4-6/6 units. UCB units engrafted had a minimum required combined cell dose of 3.7×10^7 TNC/kg before cryopreservation and each individual unit had 1.5×10^7 TNC/kg pre-cryopreservation. The median pre-cryopreserved combined doses of TNC and CD34+ progenitors were 5.16×10^7 and 1.9×10^5 per kg respectively. The two CBUs were administered sequentially 1 and 6hr apart, with the unit with higher pre-cryopreservation TNC dose being administered first. Patients achieved ANC (>500 cells/mm³) ranging from 13-70 days (median = 21 days) and platelet engraftment at 42 days. Grade II-IV acute GVHD developed in three of 32 patients and chronic GVHD developed in four of 32 patients. Non-relapse mortality at 100 days and 2 years were 12.5% and 34.4% respectively. Chimerism was evaluated among 29 patients who survived, to determine the relative contribution to hematopoiesis. At day 100, 62% of the surviving patients showed evidence of single CBU dominance while both units contributed to hematopoiesis in the remaining patients. The first infused unit was observed to be responsible for the majority of hematopoiesis in 61% of the patients who showed single CBU dominance. Among the patients with single cord predominance at day 100, 67% had only single unit contributing to hematopoiesis while the remaining patients had evidence of single unit early graft rejection or loss. The median time to relapse after transplantation was 12.6 months while DFS and OS at two years were 31.2% and 53.1% respectively. Comparing to the study performed by Ballen *et al.*, there was no significant difference between engraftment rates. However, the incidences of acute GVHD were significantly lower ($p=.035$). It is speculated that the use of sirolimus and tacrolimus GVHD prophylaxis reduced the GVHD occurrence since both studies used the

same RIC and UCB selection algorithm. Similar results were achieved in studies performed by Ballen (2007) and Rodrigues (2009) in which recipients DFS rates of 55% and 57%, respectively.

In most patients, only one of the two units gives rise to donor hematopoiesis (Ballen *et al.*, 2007; Brunstein *et al.*, 2007; Cutler *et al.*, 2010). However, this strategy has been shown to improve engraftment (Scaradavou *et al.*, 2010). Moreover, a reduced risk of relapse but higher incidence of acute GVHD may be associated with DCBT compared to single UCBT (Rocha *et al.*, 2010; Scaradavou *et al.*, 2010).

4.1.1 Double vs. Single Cord Blood Transplantation Using Myeloablative Conditioning

There is great difficulty in drawing conclusions from data results when there isn't much data to consider. DCBT TNCs were normally greater than 3.5×10^7 which is approximately two fold greater than single UCBTs. ANC engraftment rates were similar between double and single UCBTs that use MA conditioning regimens. The ANC engraftment days for DCBTs were 23, 24, 25, and 25, which are comparable to results using single UCBTs. Prevalence of acute II-IV GVHD were diverse among studies in both single and DCBTs, however, the rate of acute II-IV GVHD seemed higher in DCBTs. Chronic GVHD were also diverse between studies of single and DCBTs, but overall seemed to be lower in DCBTs. The percentage of DFS following one or two years in DCBTs was 57, 52, 56, and 51, which appeared to be lower than single UCBTs.

5. *Ex Vivo* Expansion

The other method of overcoming low cell dose of UCB is expansion of UCB HSCs. Primitive hematopoietic progenitor cells such as CD 133⁺ and CD 34⁺ from UCB are cultured with cytokines, growth factors and other growth promoting compounds in liquid culture (Tung *et al.*, 2010). The growth factors that are cultured with hematopoietic progenitor cells usually include stem cell factor (SCF), interleukin (IL)-3, IL-6, granulocyte colony-stimulating factor (G-CSF), thrombopoietin (TPO) and Flt-3 Ligand (FL) (Tung *et al.*, 2010). Several other techniques have been attempted to further improve the expansion such as the use of histone deacetylases to promote HSC self-renewal, glycogen synthase kinase-3 inhibitors to maintain pluripotency of stem cells and tetraethylenepentamine to stimulate *ex vivo* expansion of hematopoietic progenitors (Peled, Landau, Prus, Treves, & Fibach, 2002; Sato, Ozaki, Oh, Meguro, Hatanaka & Nagai, 2007; Young *et al.*, 2004).

Another technique to expand UCB is to provide a microenvironment for HSCs that will regulate differentiation and proliferation of HSCs and provide cues that direct hematopoiesis (Tung *et al.*, 2010). One potential attempt to accomplish this is by co-culturing HSCs with MSCs. MSCs derived from the Wharton's jelly of an UC provide stromal support for cord blood HSCs. (Bakhshi *et al.*, 2008) In the long-term culture-initiating cell assay, UC MSCs were proven to effectively support the growth of CD34⁺ cells from UCB. Other research suggests co-transplanting MSCs with HSCs in UCBTs (Noort *et al.*, 2002). Co-transplantation may promote engraftment of UCB CD34⁺ cells. McNiece *et al.* (McNiece, Harrington, Turney, Kellner, & Shpall, 2004) isolated and cultured mononuclear cells from UCB on MSC layers *ex vivo* and observed a 10-20 fold increase in TNC, a 7-18 fold increase in committed progenitor cells, a 2-5 fold increase in primitive progenitor cells and a 16-37 fold increase in CD34⁺ cells after 14 days. Based on previous research, co-culturing HSCs with MSCs may prove to be a potentially effective therapeutic application in HSC transplantation.

6. Blood Extraction and Processing

UCB is currently collected for one of two reasons— (i) donation for public use or (ii) storage for self or family members who are suffering from a disease that can be cured by HSC transplantation (Ballen, Barker, Stewart, Greene, & Lane, 2008). Expecting mothers must meet certain criteria to be eligible to donate UCB of the newborns. The general eligibility guidelines for expectant mothers, according to the National Marrow Donor Program (National Marrow Donor Program, 2010a), are listed below:

- (i) Be at least 18 years of age
- (ii) Have no history of hepatitis B or C, HIV, medication-dependent diabetes and cancer
- (iii) Have no history of organ transplantation
- (iv) Have no history of sexually transmitted diseases within the last 12 months
- (v) Have not had tattoos, non-sterile piercings or acupuncture done in the previous 12 months
- (vi) Have no malaria history within last three years

UCB is collected after delivery either before placental separation from the uterus wall or after placenta delivery (Ballen *et al.*, 2008). Lifeforce Cryobanks, ViaCord and New England Cord Blood Bank have similar procedures of collecting UCB (Lifeforce Cryobanks, 2011; New England Cord Blood Bank, 2011; ViaCord, 2011). The cord of the baby is clamped and cut postnatally. After the UC is rinsed with antiseptic solution, the umbilical

vein is punctured with a needle connected to a standard blood collection bag that contains anticoagulant. Blood flows into the bag by gravity, and after flow stops, the bag is detached and stored away for further processing. This simple procedure used by UCB banks corresponds with the UCB collection technique by Adami *et al.* (Adami *et al.*, 2005). In this method, the UC was double clamped within 30sec after newborn delivery, and blood was collected while placenta was *in utero*. The anticoagulant used in the collection bag was citrate-phosphate-dextrose. A similar procedure has been done by Elchalal *et al.*, except that the cord was ligated before clamping to avoid tissue crushing. The UC was then cut between the clamp and ligation. Moreover, massaging or “milking” of the cord was performed at the end of blood flow (Elchalal *et al.*, 2000).

It is important to be cautious when collecting UCB to obtain high-quality CBUs for transplantation. The major issues involved with UCB collection include the volume of UCB collected, microbial infection, delay in blood collection, and blood coagulation (Ballen *et al.*, 2008).

6.1 Cryopreservation

The storage process for HSCs is termed cryopreservation and is outlined in **Figure 5**. UCB is first treated with chemicals such as starch or ammonium chloride to reduce plasma and red blood cell (RBC) counts. RBCs typically lyse easily when they are frozen or thawed. Research suggests that these cell lysates may have detrimental effects when the HSCs are used for transplants (Regidor *et al.*, 1999). Chemical treatment additionally helps reduce blood volume, allowing for easier storage and reduction of cellular debris upon thawing. Once RBCs are depleted, a freezing medium containing dimethyl sulfoxide (DMSO) is added. DMSO is a cryoprotectant that helps preserve the cells from the sub-zero temperatures used during the cryopreservation process. The HSCs will freeze at a controlled rate of 1°C /1 min until -80°C. This process is usually carried out overnight. Several studies have indicated that freezing cells at a controlled rate increases cell viability (Perez-Oteyza *et al.*, 1998, Balint *et al.*, 2006). The HSCs will then be transferred into a liquid nitrogen tank at a temperature of -196°C. The nitrogen tank typically consists of numerous compartments that help in the labeling and identification process.

6.2 Banking

There are two types of UCB banks, public and private (**Table 3**). Public banking is the more widely used of the two and stores donated stem cells to the public registry. Access to stem cells is provided on a first-come first-serve basis. The donation is done with the consent of the mother and at no cost to the family. When a patient needs an UCBT, he/she will have up to a 90% chance of finding a compatible transplant in a public bank (Novello-Garza *et al.*, 2008). The costs of the transplant, which are generally covered by insurance, range from \$15 000-\$25 000.

Private blood banking stores cord blood exclusively for the family of the newborn. Mothers who have had a history of a particular disease in their family that may require a stem cell transplant in the future typically choose this type of banking. The cord blood transplant is guaranteed to be 100% compatible with the child of the mother. However, this percentage decreases drastically to 25% compatibility with any relative (J. Wagner *et al.*, 1996). Banking privately costs about \$1 500 in down payment and \$150-\$200 annually. When a transplant is needed, the CBU is released at no cost to the patient.

7. Conclusion

DCBT and *ex vivo expansion* of HSCs have expanded transplantation into all patients, despite of size or ethnicity. The results of these expansion techniques require a better understanding of the biological processes that occur. The spread and rise of HSC transplantation centers promises further research in the field. Such research may reveal better methods for improving overall GVHD and survival rates in patients who receive HSC transplantations.

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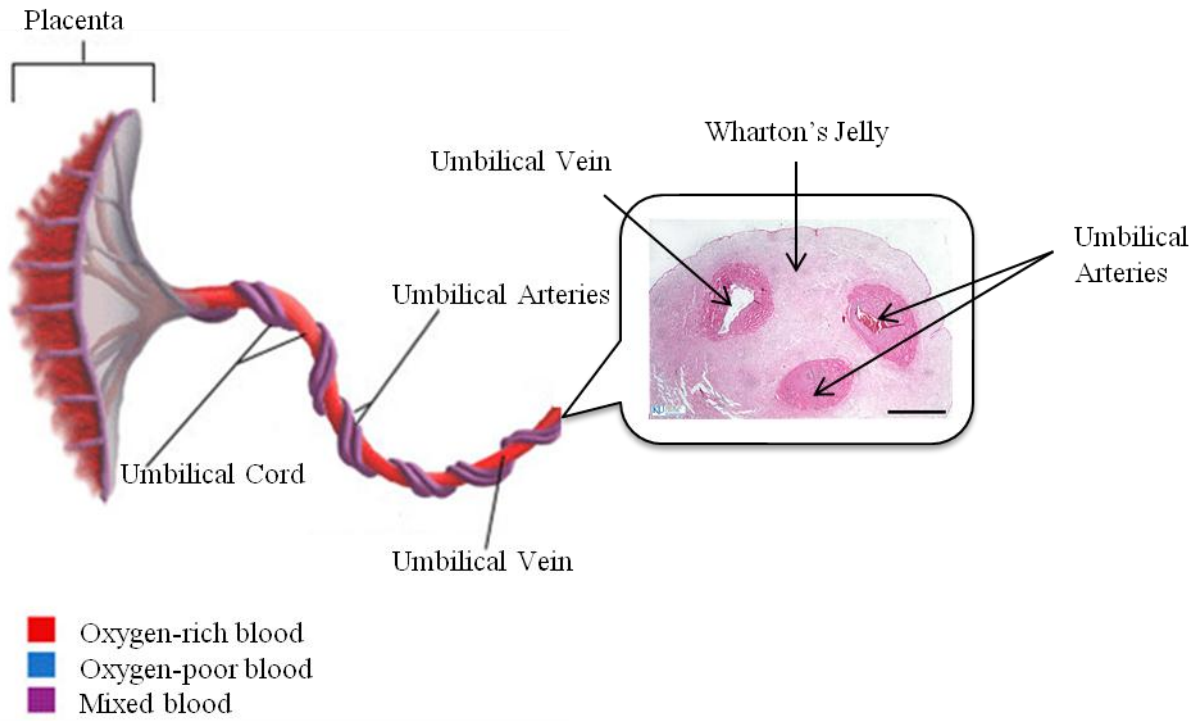


Figure 1. The anatomy of the umbilical cord. (Adapted from University of Alabama at Birmingham Medicine, 2008 and University of Kansas Medical Center, 2011)

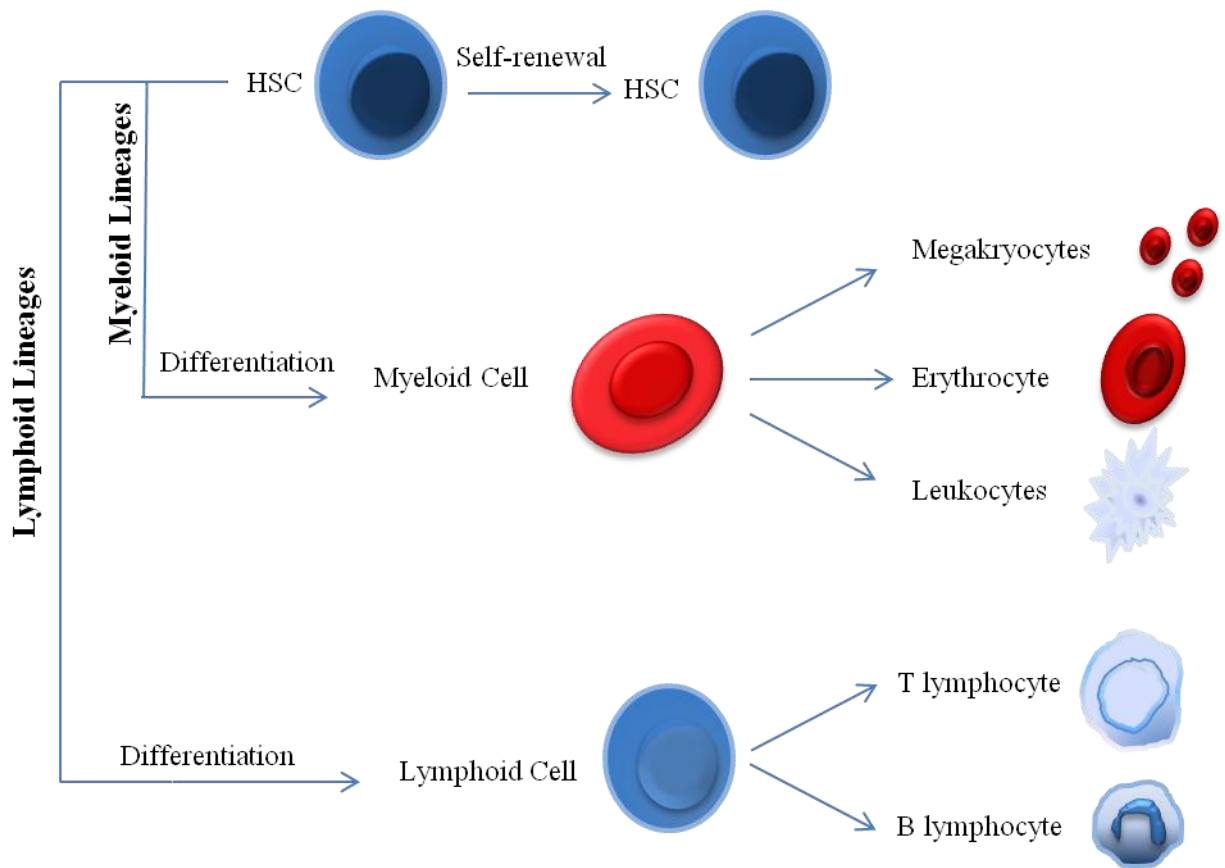


Figure 2. Differentiation pattern of HSCs.



• One transplant center in the National Marrow Donor Program Network
 (The spots are not indicative of exact location within each state)

Figure 3: Locations of HSC transplantation centers in the United States (National Marrow Donor Program, 2010b).

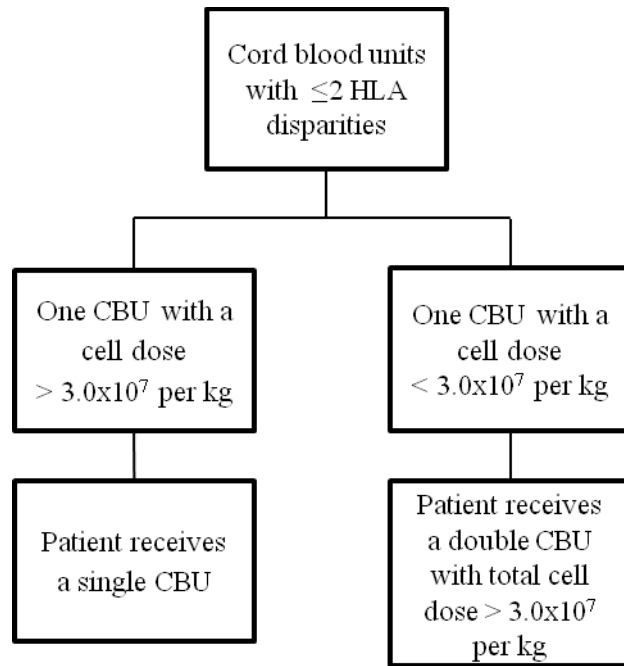


Figure 4. The common algorithm used for UCB selection. (Adapted from Wagner, 2009)

Table 1. Clinical studies comparing unrelated myeloablative single UCBT vs. 6/6 HLA matched BMT in adults

Study	N-UCB N-BM	Median age (years)	Diagnosis	Median infused TNC x 10 ⁸ /kg	Engraftment			GVHD (%)		DFS (%) (follow up in months)
					ANC (Day)	Platelets (Day)	Primary failure (%)	Acute II- IV	Chronic	
Rocha [¶] (2004)	98	24.5	AML, ALL	0.23	26	N/S	20	26	30	33 (24)
	584	32		2.9	19	N/S	7	39	46	38 (24)
Laughlin [¥] (2004)	150	N/S	AML, ALL, CML, MDS	0.22	27	60	30	41	51	23 (36)
	367	N/S		2.4	18	29	N/S	48	35	33 (36)
Takahashi [‡] (2004)	68	36	AML, ALL, CML, MDS, NHL	0.25	22	40	8	50	78	74 (24)
	39	26		N/S	18	25	0	75	74	44 (24)

Abbreviations: ALL = acute lymphocytic leukemia, AML = acute myeloid leukemia, CML = chronic myelogenous leukemia, NHL = non-Hodgkin's lymphoma, MDS = myelodysplastic syndrome, TNC = total nucleated cell, ANC = absolute neutrophil count, GVHD = graft versus host disease, DFS = disease free survival, N/S = not stated

[¶] For UCBTs, 6 patients received 6/6 HLA-matched units, 85 patients received 4-5/6 HLA-matched units, and 4 patients received 3/6 HLA-matched units.

[¥] All UCBT patients received 4-5/6 HLA-matched units.

[‡] BMT outcomes also include 6 patients who received 5/6 HLA-matched units. For UCBTs, 51 patients received 4-5/6 and 17 received 2-3/6 HLA-matched units.

Table 2. Clinical results of DCBTs using MA/NMA/ or RIC conditioning regimens in adults

Study	N-DCBT	Median age(years)	Diagnosis	Conditioning regimen	Median infused TNC x 10 ⁷ /kg	Engraftment			GVHD (%)		DFS (%) (follow up in months)
						ANC (Day)	Platelets (Day)	Primary failure (%)	Acute II-IV	Chronic	
Barker (2005)	23	24	ALL, AML, CML	MA	3.5	23	N/S	0	65	23	57 (10)
Cutler (2010)	32	53	ALL, AML, CML, NHL, HD, MDS, CLL, MD	RIC	5.16*	21	42	0	9	13	31.2 (24)
Ballen (2007)	21	49	ALL, AML, CLL, MDS, NHL, HD, AA	RIC	4.0	20	41	10	40	26	55 (24)
Kanda ^{&} (2010)	27	33	ALL, AML, CML, MDS, NHL, HD	MA	3.8	24	N/S	12	37	32	52 (24)
Brunstein [~] (2007)	93	51	High risk hematologic disease	NMA	3.7	12	N/S	6	59	23	38 (36)
Majhail (2006)	9	28	HL	RIC	3.8	10	N/S	0	67	11	25 (17)
Barker (2009)	35	42	Acute leukemia, NHL, HD, MDS	MA	4.46	25	50	6	44	26	56 (12)
	19			NMA		10	38	5			
Rodrigues (2009)	26	41	NHL, HL, CLL	RIC	3.02	17	N/S	N/S	32	19	57 (18)
Yoo [‡] (2010)	64	10.3	ALL/ABL, AML, MDS/JMML, SAA, CML	RIC	4.37	19	46	N/S	41	39	36.9 (60)
Verneris (2009)	93	24	ALL, AML, High-risk CR1	MA	3.6	25	N/S	N/S	48	18	51 (60)

Abbreviations (also see Table 1): HD = Hodgkin's disease, CLL = chronic lymphocytic leukemia, MD = myeloproliferative disorder, AA = aplastic anemia, HL = Hodgkin's lymphoma, ABL = acute biphenotypic leukemia, JMML = juvenile myelomonocytic leukemia, SAA = severe aplastic anemia, MA = myeloablative, NMA = non-myeloablative, RIC = reduced intensity conditioning, N/A = not available

*Pre-cryopreservation

[&] Article in Press.

[‡] Pediatric study

[~] Outcomes include single and DCBTs.

Table 3: Comparison between public vs. private UCB banking.

Categories	Public Bank	Private Bank
Purpose of storage	Donate stem cells to public	Keep stem cells for own children
Compatibility	Percentage of finding a match for a transplant is up to 90%	Assures 100% match for transplantation
Probability that you will need a stem cell transplant	N/A	Probability to use your own UCB is 0.04% - 0.0005%
Costs to store	Generally covered by insurance	Must pay \$1000-2000 to begin banking and \$100 - \$200 annually
Costs to retrieve stem cells from the bank	Generally covered by insurance	Does not cost money for retrieval

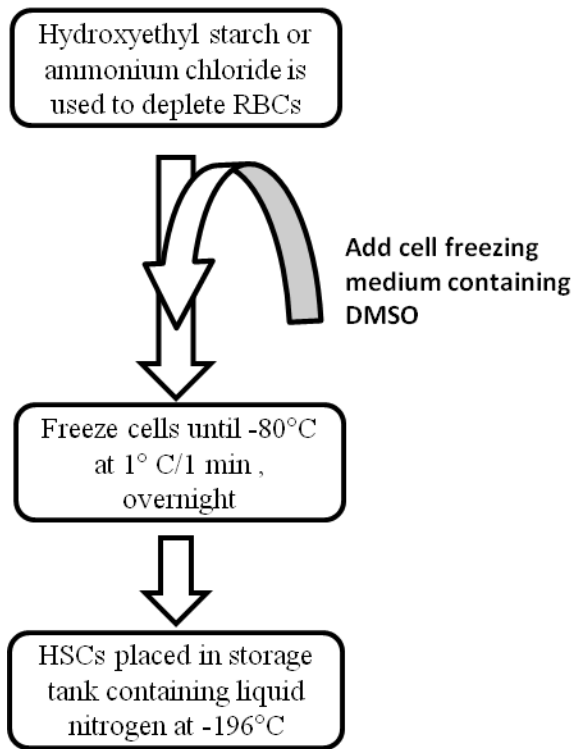


Figure 5. The common cryopreservation process of UCB.

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Appendix I

Survey Questions

Stem Cells from Umbilical Cord Blood

The umbilical cord is typically thrown away after the delivery of the baby. Scientists have determined that blood within the umbilical cord is rich in blood-forming stem cells. These stem cells are currently banked and used as therapeutic treatments for blood disorders such as leukemia and heart disease.

* Required

1. Gender *
 - Male
 - Female
2. Are you a student or faculty? *
 - Student
 - Faculty
3. Are you aware of umbilical cord blood banking? *
 - Yes
 - No
4. Please copy and paste the link below into your browser for an informative and brief video on umbilical cord blood banking. Did you find the video useful? *
<http://www.youtube.com/watch?v=DNbE7SVxLf8&fmt=18>
 - Yes
 - No
5. Would you consider banking umbilical cord blood? *
 - Yes
 - No
6. Would you consider public or private banking? *
 - Yes
 - No
7. Should federal or state funds be provided for education on umbilical cord blood banking? *
 - Yes
 - No
8. Should hospitals actively encourage women to donate umbilical cord blood? *
 - Yes
 - No

Survey Responses

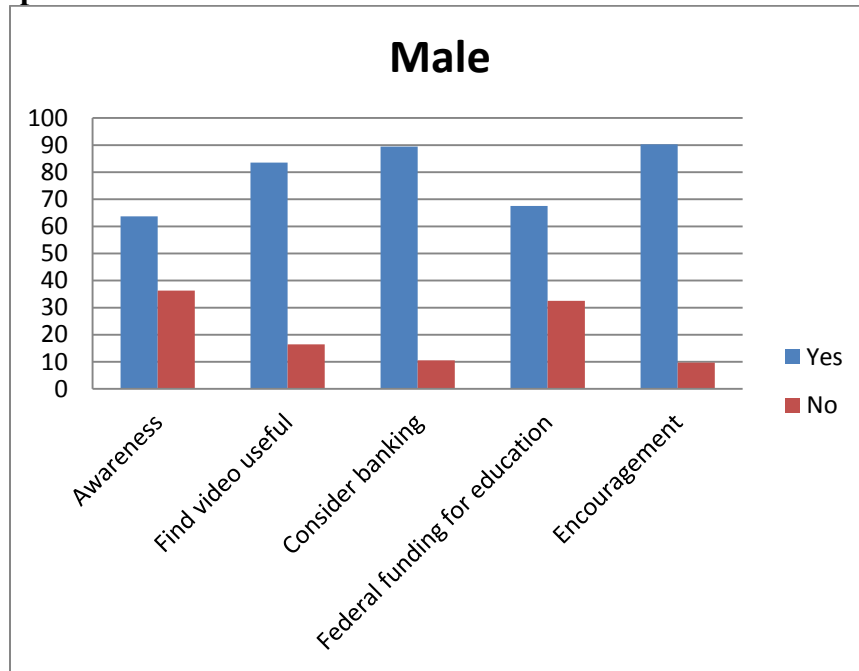


Figure 1. Various responses of male WPI students regarding survey questions.

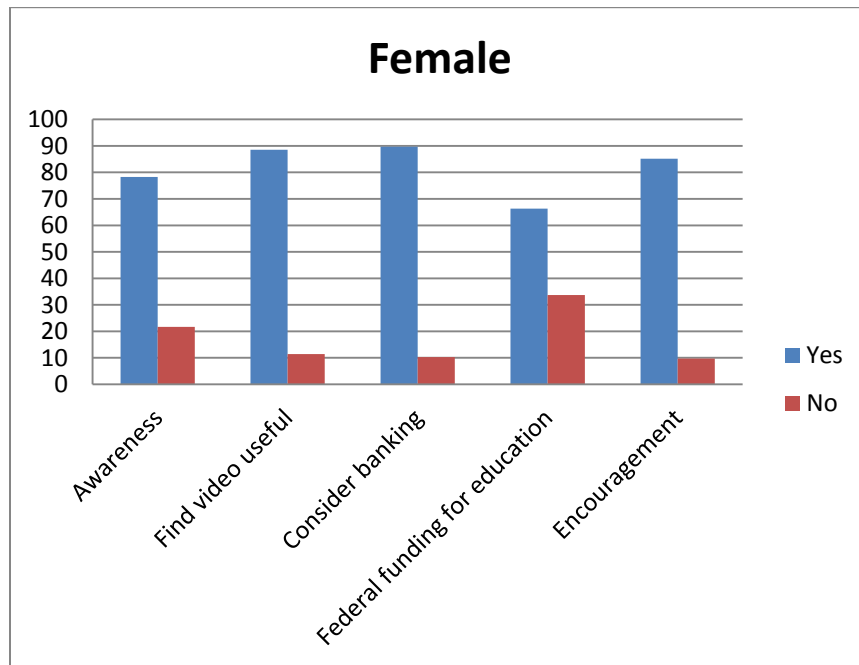


Figure 2. Various responses of female WPI students regarding survey questions.

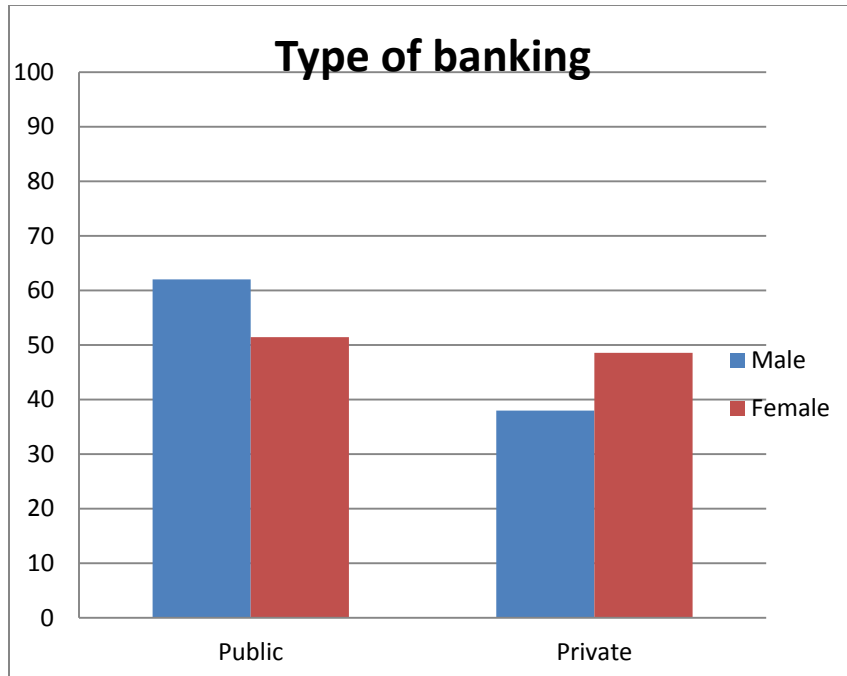


Figure 3. Various responses of male and female WPI students regarding banking options.

Appendix II

Email Correspondence with Journal Editor (Global Journal of Health Science)

Sent: Thu 9/9/2010 1:19 PM

Subject: Article Submission Inquiry (Global Journal of Health Science)

Dear Dr. Song,

My partner and I are junior undergraduate students from Worcester Polytechnic Institute, majoring in Biomedical engineering/Mechanical Engineering and Biology/Biochemistry, respectively.

We are currently pursuing a one year long evidence based research project related to stem cells extracted from the umbilical cord and umbilical cord blood postnatally. Additionally, we plan to examine the ethical and social issues concerning umbilical cord blood banking. We are preparing a journal article based on our findings. Please let us know if this paper may be suitable for publication in your journal.

Thank you. We are looking forward to hearing from you soon.

*Mortada Najem
Biology/ Biochemistry 2012
Worcester Polytechnic Institute
100 Institute Road
Worcester MA, 01609*

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*Kyaw Thu Minn
Biomedical Engineering/ Mechanical Engineering 2012
Worcester Polytechnic Institute
100 Institute Road
Worcester, MA 01609*

Sent: Thurs 9/9/2010 04:37 PM

Subject: RE: Article Submission Inquiry (Global Journal of Health Science)

Hi, Kyaw and Mortada

Thank you for your inquiry. Stem cell biology and regenerative medicine are hot research fields. Of course, your research is suitable for publication in Global Journal of Health Science.

I am very glad to hear that you guys, as a undergraduate, are interested in stem cell research and get some interesting results. I encourage you to submit to our journal and I will review your manuscript for you and try to help you publish it after peer-reviewing.

Guisheng Song

Email Correspondence with Dr. Mary Herlihy (UMASS Medical Center)

Sent: Fri 9/24/2010 4:11 PM
Subject: Cord Blood Donation Program

Dear Dr. Herlihy,

My partner and I are junior undergraduate students from Worcester Polytechnic Institute, majoring in Biomedical engineering/Mechanical Engineering and Biology/Biochemistry, respectively. We noticed that you have a clinical interest in umbilical cord blood donation. We are pleased to learn that you founded the cord blood donation program at UMASS Memorial.

We are also very interested in the umbilical cord blood donation due to its vast benefits. We are currently pursuing a one year long evidence based research project related to stem cells extracted from the umbilical cord blood postnatally. In addition to the information we will obtain from our articles research, we would like to understand more on the processes of cord blood collection and donation performed in a hospital setting. We believe you can provide us with valuable information for our research. This information will help strengthen our knowledge on the processes of cord blood donation, collection and storage. In our research paper, this will help us better portray the importance of cord blood donation program to the public.

Thank you. We are looking forward to hearing from you soon.

*Mr. Kyaw Thu Minn
Biomedical Engineering/ Mechanical Engineering 2012
Worcester Polytechnic Institute
100 Institute Road
Worcester, MA 01609*

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*Mr. Mortada Najem
Biology/ Biochemistry 2012
Worcester Polytechnic Institute
100 Institute Road
Worcester MA, 01609*

Sent: Mon 10/27/2010 8:03 AM
Subject: RE: Cord Blood Donation Program

Certainly - would love to talk. I have included my scertary on this email, she can help arrange.
Often Fridays and Tuesdays are good.
Look forward to it, Mary

Email Correspondence with Dr. Rouzbeh Taghizadeh (Auxocell Laboratories)

Sent: Fri 10/15/2010 11:42 AM
Subject: Umbilical Cord Project

Dear Rouzbeh,

My partner and I have finally made our schedules. We will be free between 11:00 - 5:00 Tuesday (October 19) through Friday (October 22) of next week. Please let us know which day and which time works best for you.

We are looking forward to seeing you!

*Thank you
Mortada Najem*

Sent: Tue 10/19/2010 09:18 AM
Subject: Re: Umbilical Cord Project

Hello Mortada,

Let's aim for Friday afternoon from 3-5 PM ... Please let me know if that works for you both ...

Best,
Rouzbeh